

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/05/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254		
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F0000	<p>This visit was for the Investigation of Complaint IN00100685 and Complaint IN00101396.</p> <p>Complaint IN00100685 - Substantiated. Federal/state deficiencies related to the allegation are cited at F333 and F281.</p> <p>Complaint IN00101396 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: January 4 &amp; 5, 2012</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 38 Medicaid: 33 Other: 19 Total: 90</p> <p>Sample: 3</p>	F0000	Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on January 5, 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0281 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/10/12 by Suzanne Williams, RN</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to provide services that met professional standards of quality, related to medication administration, for 1 of 3 residents reviewed for medication errors in a sample of 3. [Resident #B]</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 01/04/12 at 3:55 p.m. and indicated the resident had diagnoses which included, but were not limited to, Alzheimer's disease, diabetes, hypothyroidism, anemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease, cardiac pacemaker, osteoporosis, gastroesophageal reflux disorder, heart block, and depressive disorder.</p> <p>Review of Resident #B's Medication Administration Record for December 2011 indicated Resident #B received scheduled 8 am medications which</p>	F0281	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on January 5, 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is practice of this facility to provide services that meet the professional standards.1. Resident B was observed for vital sign changes, MD and family were notified immediately along with the pharmacist to discuss the medications given, potential side effects and the length of time it would take for medications to be excreted and ensuring no interactions with other meds or potential for ill effects/harm to resident. None were found. Nursing staff assessed more frequently as a nursing measure and resident remained normotensive with no change to</p>	01/23/2012			

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	<p>included, but were not limited to, Metoprolol [anti-hypertensive] 50 mg [milligrams] po [by mouth] twice a day, diovan [angiotensin II receptor antagonist - used for hypertension] 160 mg po twice a day, and clonidine [anti-hypertensive] 0.1 mg po twice a day.</p> <p>Resident Progress Notes dated 12/01/11 at 2 p.m. indicated, "Resident received another res. [resident] medication this AM @ [at] 9:30/A, v/s [vital signs] 106/59 p [pulse] 60 R [respirations] 18 T [temperature] 97.2, list of meds on medication variance [sic] report, M.D. called &amp; new orders received, family aware of incident, ADON [Assistant Director of Nursing] &amp; Administrator aware v/s @ 1020 a.m. 110/62 p66 R18, v/s @ 1120/A 148/78 p65 R18, v/s @ 130/p 83/47 p61 R18, res layed down given extra fluids &amp; feet elevated v/s @ 230p 88/56 p59 R16, feet remain elevated &amp; fluids encouraged, family updated."</p> <p>Resident Progress Notes dated 12/01/11, late entry for 10:30, indicated, "Informed of above incident. Resident assessed &amp; no distress noted. VSS [Vital Sign Stable] at present c [with] B/P 110/62. NP [Nurse Practitioner] [name of NP] called &amp; notified of above events, since he has followed her here &amp; knows her</p>		<p>mentation. Nurses continued to assess resident and her medications, notifying Doctor with concerns or questions ensuring resident safety. Resident noted at 12:20pm in main dining room joking with daughter, 4:00pm resident stated "she felt great", 6:00pm resident in good spirits, alert, wheeling self to dining room, 8:00pm showering without complaints and at 10:00pm sleeping but easy to arouse thus exhibiting no ill effects or harm to resident. Orienteer nurse was removed immediately from assignment and terminated. The nurse preceptor was counseled same day regarding appropriate orientation process.2. All residents that were included in the affected assignment were reviewed by the Director of Nursing and it was found that no other residents had been affected. During the survey process, four separate nurses were subsequently observed by the state surveyor in various medication passes with no findings of errors or deviations from the facility policy or procedure practices were noted on January 4th or 5th 2012.3. Staff nurses were inserviced on the policy and procedure for medication administration on 12/5/11, 12/10/11, 1/4/12, 1/5/12, 1/6/12, 1/7/12, 1/8/12, 1/9/12 and 1/10/12. All new RN/LPN's will continue to be required to pass an intial</p>		

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	<p>well. Office was called earlier. List of meds communicated to him via phone that res received by error. He stated to cont [continue] to watch vitals &amp; hold 2 pm B/P med. No other orders."</p> <p>Resident Progress Notes dated 12/01/11, late entry for 12:30 p.m., indicated, "Found resident in MDR [main dining room] having lunch with daughter. Resident alert &amp; oriented to self &amp; eating lunch. No distress noted. Resident joking c her daughter. Current B/P @ 1220 pm 145/78 &amp; pulse 65."</p> <p>Resident Progress Notes dated 12/01/11 at 4 p.m. indicated, the resident was up in a wheelchair with blood pressure in left arm 108/61 and pulse 61, blood pressure in right arm 113/63 and pulse 62. Resident indicated she felt "great."</p> <p>Resident Progress Notes dated 12/01/11 at 6 p.m. indicated, "Resident up in w/c [wheel chair] propelling self back to unit from D/R [dining room]. Resident alert et [and] responsive s [without] c/o [complaint of] voiced v/s 135/73 (L) [left] arm 128/71 (R) [right] arm - 61 - 20 - 97.9 o2 [oxygen] sat [saturation] 93% R/A [room air] resp [respirations] even non-labored. Resident in good spirits fluids encouraged frequently this evening."</p>		<p>medication administration pass with the Staff Development Coordinator and subsequently must have at least three further preceptor observed and signed medication passes in orientation prior to being able to pass medications independently.4. The Director of Nursing and/or designee will audit medication passes/administration that includes at least 10% of nurses randomly selected per week. Any nurse found out of compliance will be immediately removed from the floor and terminated as this facility stands firm with providing the best quality of care possible to its residents. The results will be reviewed monthly in quality assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor for quality compliance.5. Administrator will ensure compliance by January 23, 2012.</p>		

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	<p>Resident Progress Notes dated 12/01/11 at 8 p.m. indicated the resident had her shower, remained alert and responsive, left arm blood pressure 116/64, right arm 124/68. The notes indicated the Dr.'s [doctor's] office called related to blood pressure and giving blood pressure medications. "M.D. [Medical Doctor] to hold 8 P [P.M.] B/P meds tonight. Notified Dtr. [daughter] [first name of daughter] of new orders et Resident's condition. Resident denies pain/discomfort @ this time. Will continue to encourage fluids."</p> <p>Resident Progress Notes dated 12/01/11 at 9 a.m., late entry for 12/01/11 @ 2 p.m., indicated, "Pharmacy called &amp; notified of meds resident received in error &amp; make sure they would not interact c her current meds. Pharmacist stated there were no concerns with meds taken. I also asked how long meds would be active in system, Pharmacist stated 4 - 8 hours. No distress noted at current."</p> <p>Resident Progress Notes dated 12/01/11 at 10 p.m. indicated right arm blood pressure 130/72 and left arm blood pressure 121/68, eyes closed, and arouses to verbal stimuli.</p> <p>Nurse Practitioner visit notes dated</p>				

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	<p>12/02/11 indicated, "Pt. [Patient] received wrong meds yesterday along c her routine meds. NP notified NO [new orders] hold all p.m. meds yest [yesterday] &amp; monitor for changes and v/s x [times] 24 hours. Pt. is her normal self today - v/s stable."</p> <p>Interview with the Administrator on 01/04/12 at 5:15 p.m. indicated Resident #B had been given Resident #A's medications.</p> <p>Review of Resident #A's clinical record on 01/05/12 at 9:35 a.m. and review of Resident #A's Medication Record for December 2011, indicated Resident #A was to receive the following 8 a.m. medications, but Resident #B ended up receiving: aspirin [anti-coagulant] 81 mg [milligrams] po [by mouth] qd [every day], wellbutrin sr [anti-depressant] 150 mg po qd, hydrochlorothiazide [diuretic anti-hypertensive] 25 mg 1 tab op qd, lisinopril [anti-hypertensive] 5 mg 1 tab po qd, effexor [anti-depressant] 75 mg 1 tab po twice a day, zyprexa [anti-psychotic] 5 mg po q [every] a.m. [morning], duoneb one vial per nebulizer every 4 hours while awake times 10 days, multiple vitamin with minerals one tab po qd, senna [for constipation] 2 tabs po qd, brimonide ophth 1 drop both eyes twice a day, and pilocarpine ophth one drop both eyes three times a day.</p>				

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	<p>Interview with the Director of Nursing [DON] on 01/05/12 at 10:15 a.m. indicated the facility had LPN #1 orienting on the unit with LPN #2 and LPN #2 felt secure with LPN #1 performing medication pass. LPN #1 gave Resident #B the wrong medications and LPN #1 was terminated and LPN #2 was reprimanded. LPN #2 had found the error. The DON indicated LPN #1 did not follow the 5 rights of medication administration, which is basic nursing.</p> <p>Interview with LPN #2 on 01/05/12 at 1:15 p.m. indicated she was orienting a new nurse, LPN #1, and they were on the same med cart together passing morning medications. LPN #2 indicated she would pass one resident their meds and let LPN #1 set up the next resident's medications, and she would check them to make sure they were correct before administration. LPN #2 indicated they got to their last resident, Resident #A and the aides were giving the resident her bath. The aides were having some problems with the resident and she stayed to help with Resident #A and told LPN #1 to give Resident #B her duoneb which had not been given with her morning medications, as the resident gets it a couple hours later and to set up the medications for Resident #A. LPN #2 explained when she walked</p>				

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	<p>out of Resident #A's room she saw LPN #1 exiting Resident #B's room with a medication cup in her hand and asked her what was in her cup, knowing she should not have a medication cup, but a breathing treatment bullet/vial for the breathing treatment. LPN #1 told her she had given Resident #A her morning medications and LPN #2 informed her that Resident #A is in this room. LPN #2 indicated she made out a medication error report, called the doctor, informed the family and called the pharmacy. LPN #2 indicated the doctor said to monitor the resident's vital signs every shift, but they monitored vital signs every 15 minutes as a nursing measure only because she had so many blood pressure pills. LPN #2 indicated the doctor was notified a couple times during the day and they elevated Resident #B's feet and encouraged an increase in fluids. LPN #2 indicated Resident #B's daughter works at the facility and she was pretty upset and they kept her informed when the resident's blood pressure decreased. LPN #2 indicated LPN #1 got terminated and she got wrote up for not being side by side with the orienting nurse. LPN #2 indicated LPN #1 had done fine with the meds prior. LPN #2 indicated the facility did educate LPN #2 on the 5 rights of medication pass and told her to make sure she had the right resident.</p>			

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	<p>Review of the facility's Personnel Action Request (PAR) dated 12/01/11 indicated LPN #1 was terminated and reason for separation was "Failed Hiring Process." The DON also presented an attached document dated 12/01/11 which indicated the following: "Writer and ADNS [Assistant Director of Nursing Services] [name of ADNS] spoke with nurse [name of LPN #1] today regarding incident with resident [Resident #B's initials]. Nurse [name of LPN #1] stated that she had been asked to pass medications to a resident but she had failed to indentify [sic] the appropriate resident for the medications. During the conversation, writer explained that ALL nurses are taught the 6 rights of medication administration (right patient, right time, right dose, right medication, right route, right documentation) during nursing school and those actions do not disappear during their entire practice as a nurse. Nurse [name of LPN #1] stated that she understands the six rights but she in turn failed to follow those and inadvertently administered the wrong medications to the wrong patient. Nurse [name of LPN #1] was discharged of her duties immediately due to not following proper procedures." This document was signed by the Director of Nursing and dated 12/01/11.</p> <p>Review of the facility's Medication</p>				

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	<p>Administration policy dated 08/31/11 indicated, "The nursing staff uses the medication cart systematically to distribute physician ordered medications to patients. Authorized personnel administer the medications, including medications needing intravenous administration. Staff assignments and work allocations are scheduled so that sufficient authorized staff is available to administer medication in order to meet the needs of the patients. ... Prepare the medication using the five rights of medication administration: a. Right patient, b. Right medication name and strength, c. Right time of administration, d. Right frequency, e. Right route of administration f. Reason, and g. Documentation. ... Administering the Medication ... Take the medication to the patient's location, and identify the patient.</p> <p>Review of LPN #1's employee file on 01/05/12 at 4:38 a.m. indicated LPN #1 had been checked off on 11/28/11 for oral medication administration and had practiced the five rights before giving the medication.</p> <p>LPN #1's Job Description for Licensed Practical/Vocational Nurse indicated, "Summary: Coordinates and provides nursing care for residents and provides supervision and guidance to clinical staff</p>						

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F0333 SS=D	<p>members. Scope of work may be modified by state specific rules under the Nurse Practice Act. ... Essential Functions: ... Administers medications and performs treatments for assigned residents, and documents that treatment as required by Kindred, and local, state and federal rules and regulations...." The Job Description was signed by LPN #1 and the department manager and dated 11/15/11.</p> <p>Review of the Fundamentals of Nursing Made Incredibly Easy by Lippincott, Williams, and Wilkins, 2006, indicated, "... Following a tried-and-true set of safeguards known as the 5 rights can quickly and easily help you avoid the most basic and common sources of medication error. Each time you administer a medication, confirm that you have the right drug, right dose, right patient, right time, right route...."</p> <p>This federal deficiency is related to Complaint IN00100685.</p> <p>3.1-35(g)(1)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free of a significant medication error for 1 of 3</p>	F0333	Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on January 5, 2012. The	01/23/2012

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	<p>residents reviewed for medication errors in a sample of 3. [Resident #B]</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 01/04/12 at 3:55 p.m. and indicated the resident had diagnoses which included, but were not limited to, Alzheimer's disease, diabetes, hypothyroidism, anemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease, cardiac pacemaker, osteoporosis, gastroesophageal reflux disorder, heart block, and depressive disorder.</p> <p>Review of Resident #B's Medication Administration Record for December 2011 indicated Resident #B received scheduled 8 am medications which included, but were not limited to, Metoprolol [anti-hypertensive] 50 mg [milligrams] po [by mouth] twice a day, diovan [angiotensin II receptor antagonist - used for hypertension] 160 mg po twice a day, and clonidine [anti-hypertensive] 0.1 mg po twice a day.</p> <p>Resident Progress Notes dated 12/01/11 at 2 p.m. indicated, "Resident received another res. [resident] medication this AM @ [at] 9:30/A, v/s [vital signs] 106/59 p [pulse] 60 R [respirations] 18 T</p>		<p>facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to provide services that meet the professional standards. It is the practice of this facility to ensure a resident is free of a significant medication error.1. Resident B was observed for vital sign changes, MD and family were notified immediately along with the pharmacist to discuss the medications given, potential side effects and the length of time it would take for medications to be excreted and ensuring no interactions with other meds or potential for ill effects/harm to resident. None were found. Nursing staff assessed more frequently as a nursing measure and resident remained normotensive with no change to mentation. Nurses continued to assess resident and her medications, notifying Doctor with concerns or questions ensuring resident safety. Resident noted at 12:20 p.m. in the main dining room joking with daughter, 4:00 p.m. resident stated "she felt great", 6:00 p.m. resident in good spirits, alert, wheeling self to dining room, 8:00 p.m. showering without complaints, and at 10:00</p>		

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	<p>[temperature] 97.2, list of meds on medication variance [sic] report, M.D. called &amp; new orders received, family aware of incident, ADON [Assistant Director of Nursing] &amp; Administrator aware v/s @ 1020 a.m. 110/62 p66 R18, v/s @ 1120/A 148/78 p65 R18, v/s @ 130/p 83/47 p61 R18, res layed down given extra fluids &amp; feet elevated v/s @ 230p 88/56 p59 R16, feet remain elevated &amp; fluids encouraged, family updated."</p> <p>Resident Progress Notes dated 12/01/11, late entry for 10:30, indicated, "Informed of above incident. Resident assessed &amp; no distress noted. VSS [Vital Sign Stable] at present c [with] B/P 110/62. NP [Nurse Practitioner] [name of NP] called &amp; notified of above events, since he has followed her here &amp; knows her well. Office was called earlier. List of meds communicated to him via phone that res received by error. He stated to cont [continue] to watch vitals &amp; hold 2 pm B/P med. No other orders."</p> <p>Resident Progress Notes dated 12/01/11, late entry for 12:30 p.m., indicated, "Found resident in MDR [main dining room] having lunch with daughter. Resident alert &amp; oriented to self &amp; eating lunch. No distress noted. Resident joking c her daughter. Current B/P @ 1220 pm</p>		<p>p.m. sleeping but easy to arouse thus exhibiting no ill effects or harm to resident. Orientee nurse was removed immediately from assignment and terminated. The nurse preceptor was counseled same day regarding appropriate orientation process.2. All residents that were included in the affected assignment were reviewed by the Director of Nursing and it was found that no other residents had been affected. During the survey process, four separate nurses were subsequently observed by the state surveyor in various medication passes with no findings of errors or deviations from the facility policy or procedure practices were noted on January 4th or 5th 2012.3. Staff nurses were inserviced on the policy and procedure for medication administration on 12/5/11, 12/10/11, 1/4/12, 1/5/12, 1/6/12, 1/7/12, 1/8/12, 1/9/12 and 1/10/12. All new RN/LPN's will continue to be required to pass an intitial medication administration pass with the Staff Development Coordinator and subsequently must have at least three further preceptor passes in orientation prior to being able to pass medications independently.4. The Director of Nursing and/or designee will audit medication passes/administration that includes at least 10% of nurses</p>		

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	<p>145/78 &amp; pulse 65."</p> <p>Resident Progress Notes dated 12/01/11 at 4 p.m. indicated, the resident was up in a wheelchair with blood pressure in left arm 108/61 and pulse 61, blood pressure in right arm 113/63 and pulse 62. Resident indicated she felt "great."</p> <p>Resident Progress Notes dated 12/01/11 at 6 p.m. indicated, "Resident up in w/c [wheel chair] propelling self back to unit from D/R [dining room]. Resident alert et [and] responsive s [without] c/o [complaint of] voiced v/s 135/73 (L) [left] arm 128/71 (R) [right] arm - 61 - 20 - 97.9 o2 [oxygen] sat [saturation] 93% R/A [room air] resp [respirations] even non-labored. Resident in good spirits fluids encouraged frequently this evening."</p> <p>Resident Progress Notes dated 12/01/11 at 8 p.m. indicated the resident had her shower, remained alert and responsive, left arm blood pressure 116/64, right arm 124/68. The notes indicated the Dr.'s [doctor's] office called related to blood pressure and giving blood pressure medications. "M.D. [Medical Doctor] to hold 8 P [P.M.] B/P meds tonight. Notified Dtr. [daughter] [first name of daughter] of new orders et Resident's condition. Resident denies</p>		<p>randomly selected per week. Any nurse found out of compliance will be immediately removed from the floor and terminated as this facility stands firm with providing the best quality of care possible to its residents. The results will be reviewed monthly in quality assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor for quality compliance.5. Administrator will ensure compliance by January 23, 2012.</p>		

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	<p>pain/discomfort @ this time. Will continue to encourage fluids."</p> <p>Resident Progress Notes dated 12/01/11 at 9 a.m., late entry for 12/01/11 @ 2 p.m., indicated, "Pharmacy called &amp; notified of meds resident received in error &amp; make sure they would not interact c her current meds. Pharmacist stated there were no concerns with meds taken. I also asked how long meds would be active in system, Pharmacist stated 4 - 8 hours. No distress noted at current."</p> <p>Resident Progress Notes dated 12/01/11 at 10 p.m. indicated right arm blood pressure 130/72 and left arm blood pressure 121/68, eyes closed, and arouses to verbal stimuli.</p> <p>Nurse Practitioner visit notes dated 12/02/11 indicated, "Pt. [Patient] received wrong meds yesterday along c her routine meds. NP notified NO [new orders] hold all p.m. meds yest [yesterday] &amp; monitor for changes and v/s x [times] 24 hours. Pt. is her normal self today - v/s stable."</p> <p>Interview with the Administrator on 01/04/12 at 5:15 p.m. indicated Resident #B had been given Resident #A's medications.</p> <p>Review of Resident #A's clinical record</p>			

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	<p>on 01/05/12 at 9:35 a.m. and review of Resident #A's Medication Record for December 2011, indicated Resident #A was to receive the following 8 a.m. medications, but Resident #B ended up receiving: aspirin [anti-coagulant] 81 mg [milligrams] po [by mouth] qd [every day], wellbutrin sr [anti-depressant] 150 mg po qd, hydrochlorothiazide [diuretic anti-hypertensive] 25 mg 1 tab op qd, lisinopril [anti-hypertensive] 5 mg 1 tab po qd, effexor [anti-depressant] 75 mg 1 tab po twice a day, zyprexa [anti-psychotic] 5 mg po q [every] a.m. [morning], duoneb one vial per nebulizer every 4 hours while awake times 10 days, multiple vitamin with minerals one tab po qd, senna [for constipation] 2 tabs po qd, brimonide oph 1 drop both eyes twice a day, and pilocarpine oph one drop both eyes three times a day.</p> <p>Interview with the Director of Nursing [DON] on 01/05/12 at 10:15 a.m. indicated the facility had LPN #1 orienting on the unit with LPN #2 and LPN #2 felt secure with LPN #1 performing medication pass. LPN #1 gave Resident #B the wrong medications and LPN #1 was terminated and LPN #2 was reprimanded. LPN #2 had found the error. The DON indicated LPN #1 did not follow the 5 rights of medication administration, which is basic nursing.</p>				

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	<p>Interview with LPN #2 on 01/05/12 at 1:15 p.m. indicated she was orienting a new nurse, LPN #1, and they were on the same med cart together passing morning medications. LPN #2 indicated she would pass one resident their meds and let LPN #1 set up the next resident's medications, and she would check them to make sure they were correct before administration. LPN #2 indicated they got to their last resident, Resident #A and the aides were giving the resident her bath. The aides were having some problems with the resident and she stayed to help with Resident #A and told LPN #1 to give Resident #B her duoneb which had not been given with her morning medications, as the resident gets it a couple hours later and to set up the medications for Resident #A. LPN #2 explained when she walked out of Resident #A's room she saw LPN #1 exiting Resident #B's room with a medication cup in her hand and asked her what was in her cup, knowing she should not have a medication cup, but a breathing treatment bullet/vial for the breathing treatment. LPN #1 told her she had given Resident #A her morning medications and LPN #2 informed her that Resident #A is in this room. LPN #2 indicated she made out a medication error report, called the doctor, informed the family and called the pharmacy. LPN #2 indicated the doctor</p>			

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	<p>said to monitor the resident's vital signs every shift, but they monitored vital signs every 15 minutes as a nursing measure only because she had so many blood pressure pills. LPN #2 indicated the doctor was notified a couple times during the day and they elevated Resident #B's feet and encouraged an increase in fluids. LPN #2 indicated Resident #B's daughter works at the facility and she was pretty upset and they kept her informed when the resident's blood pressure decreased. LPN #2 indicated LPN #1 got terminated and she got wrote up for not being side by side with the orienting nurse. LPN #2 indicated LPN #1 had done fine with the meds prior. LPN #2 indicated the facility did educate LPN #2 on the 5 rights of medication pass and told her to make sure she had the right resident.</p> <p>Review of the facility's Personnel Action Request (PAR) dated 12/01/11 indicated LPN #1 was terminated and reason for separation was "Failed Hiring Process." The DON also presented an attached document dated 12/01/11 which indicated the following: "Writer and ADNS [Assistant Director of Nursing Services] [name of ADNS] spoke with nurse [name of LPN #1] today regarding incident with resident [Resident #B's initials]. Nurse [name of LPN #1] stated that she had been asked to pass medications to a</p>			

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	<p>resident but she had failed to indentify [sic] the appropriate resident for the medications. During the conversation, writer explained that ALL nurses are taught the 6 rights of medication administration (right patient, right time, right dose, right medication, right route, right documentation) during nursing school and those actions do not disappear during their entire practice as a nurse. Nurse [name of LPN #1] stated that she understands the six rights but she in turn failed to follow those and inadvertently administered the wrong medications to the wrong patient. Nurse [name of LPN #1] was discharged of her duties immediately due to not following proper procedures." This document was signed by the Director of Nursing and dated 12/01/11.</p> <p>Review of the facility's Medication Administration policy dated 08/31/11 indicated, "The nursing staff uses the medication cart systematically to distribute physician ordered medications to patients. Authorized personnel administer the medications, including medications needing intravenous administration. Staff assignments and work allocations are scheduled so that sufficient authorized staff is available to administer medication in order to meet the needs of the patients. ... Prepare the medication using the five rights of</p>			

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	<p>medication administration: a. Right patient, b. Right medication name and strength, c. Right time of administration, d. Right frequency, e. Right route of administration</p> <p>f. Reason, and g. Documentation. ... Administering the Medication ... Take the medication to the patient's location, and identify the patient.</p> <p>Review of LPN #1's employee file on 01/05/12 at 4:38 a.m. indicated LPN #1 had been checked off on 11/28/11 for oral medication administration and had practiced the five rights before giving the medication.</p> <p>LPN #1's Job Description for Licensed Practical/Vocational Nurse indicated, "Summary: Coordinates and provides nursing care for residents and provides supervision and guidance to clinical staff members. Scope of work may be modified by state specific rules under the Nurse Practice Act. ... Essential Functions: ... Administers medications and performs treatments for assigned residents, and documents that treatment as required by Kindred, and local, state and federal rules and regulations...." The Job Description was signed by LPN #1 and the department manager and dated 11/15/11.</p> <p>This federal deficiency is related to</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	Complaint IN00100685.  3.1-25(b)(9) 3.1-48(c)(2)				